The Ron Silver Senior Drug Program
"Silver Saver"
A Medicaid Section 1115 Demonstration Program

The Operational Protocol

Organizational and Structural Administration

The Agency for Health Care Administration (Agency), the single state agency, is responsible for the administration of the Florida Medicaid program. Within the Agency, the Division of Medicaid, under the direction of the Deputy Secretary for Medicaid, is responsible for the day-to-day administration of Medicaid. Within the Division of Medicaid, the Bureau of Pharmacy Services will administer the Ron Silver Senior Drug Program (Silver Saver Drug Program).

The Bureau of Pharmacy Services prepared the Section 1115 waiver application for the Silver Saver Drug Program and will promulgate the state administrative rule governing the program, direct changes to the Florida Medicaid Management Information System (FMMIS), direct the Florida Medicaid pharmacy benefits management contractor's responsibilities related to the Silver Saver Drug Program, monitor the delivery of pharmacy benefits, and assist other bureaus and divisions in completing other administrative support functions. The Bureau of Program Analysis, Division of Medicaid, and the Agency's Division of Administrative Services will be responsible for program and financial reporting required by the waiver. The Department of Children and Families, to which the Agency has delegated certain Medicaid eligibility determination functions, will receive and process applications for coverage under the Silver Saver Drug Program and transmit eligibility data to the FMMIS. The Department of Children and Families will also administer fair hearings for the Silver Senior Drug Program. The Florida Department of Elder Affairs will assist in developing marketing and outreach strategies to maximize program enrollment.

The Medicaid fiscal agent, ACS (Affiliated Computer Systems) formally known as, Consultec, is responsible for operating the FMMIS. As part of that function, ACS manages the recipient file, the provider file including provider enrollment, and the Prescription Drug Card System (PDCS) and processes pharmacy claims and prepares state and federal reports.

ACS is also under contract as the Florida Medicaid Pharmacy Benefits Manager (PBM). Under this contract, ACS is responsible for managing the Therapeutic Consultation Program (TCP) call center; processing prior authorization requests for exceptions to the 4-brand monthly drug limit for adults; handling other prior authorization requests for select therapeutic categories; operating the Medicaid Intensified Benefits Management (IBM) program (prescribed drug program data management, provider and beneficiary

profiling, provider and beneficiary education, and other cost control and utilization management interventions); managing the Therapeutic Academic Intervention (TAI) program (physician detailing); and performing other benefits management activities.

Heritage Information Systems is responsible for pharmacy desk, on-site and in-depth audits and beneficiary Explanation of Medical Benefits (EOMB) activities. Heritage also provides staff support to the Medicaid Prescribing Pattern Review Panel.

Another Agency contractor, Provider Synergies, assists the Agency in negotiating drug manufacturer state supplemental rebates and providing clinical support to the Medicaid Pharmaceutical and Therapeutics Committee. Scores of pharmaceutical manufacturers have state supplemental rebate agreements with Florida Medicaid.

The Agency contracts with the Florida Pharmacy Association for state and local Drug Utilization Review (DUR) activities. Florida Medicaid also has contracts with disease management organizations to provide care management for beneficiaries with a variety of chronic conditions, including asthma, congestive heart failure, diabetes, end stage renal disease, hemophilia, HIV/AIDS, hypertension and mental illness.

Implementation Timeline

The following table includes timelines for various project implementation tasks, including implementation steps, implementation timelines, and responsible parties.

The Silver Saver Drug Program Implementation Plan		
Activity	Responsible Party	Timeline
Modify FMMIS (recipient file) to establish new program/eligibility category	Division of Medicaid, Bureau of Contract Management and ACS	July 2002 Complete
Modify QMB/SLMB designation to convert benefits from state pharmacy assistance program to Silver Saver Drug Program and benefits	Division of Medicaid, Bureau of Contract Management and ACS	July 2002 Complete
Establish the QMB/SLMB-like drug-only eligibility category (no asset test group)	Division of Medicaid, Bureau of Contract Management and ACS	July 2002 Complete

The Ron Silver Senior Drug Program Implementation Plan		
Activity	Responsible Party	Timeline
Modify the claims subsystem and recipient subsystems to create an enrollment cap, a waiting list, an enrollment accumulator, and a process for converting individuals on the waiting list to active list in date order	Division of Medicaid, Bureau of Contract Management and ACS	July – August 2002 In process
Modify the Prescription Drug Card System (PDCS) to include new benefit limit and co-payment information for pharmacy point of sale system	Division of Medicaid, Bureau of Contract Management and ACS	July 2002 Complete
Develop new, simplified application form for new eligibility category of Silver Saver Drug Program beneficiaries (no asset test)	Department of Children and Families	July 2002 Complete
Train eligibility workers on new category and application processing	Department of Children and Families	July 2002 In process
Modify the Florida Medicaid Eligibility System, FLORIDA, to contain and transmit data to FMMIS on Silver Senior Drug Program eligibles	Division of Medicaid, Bureau of Contract Management, ACS and Department of Children and Families	July - August 31, 2002 In Process
Test and modify, as needed, changes to FMMIS and FLORIDA	Division of Medicaid, Bureau of Contract Management, ACS and Department of Children and Families	August 1 – 31, 2002
Implement system modifications	Division of Medicaid, Bureau of Contract Management, ACS and Department of Children and Families	August 1, 2002 and September 1, 2002

The Ron Silver Senior Drug Program Implementation Plan		
Activity	Responsible Party	Timeline
Convert QMB/SLMB eligibles to new drug program coverage	Division of Medicaid, Bureau of Contract Management and ACS	August 1, 2002 In Process
Notify QMB/SLMB eligibles of new drug benefit; prepare and conduct beneficiary mailing	Division of Medicaid, Bureau of Contract Management, ACS and Bureau of Pharmacy Services	Ongoing
Notify Medicaid enrolled pharmacies of program changes	Division of Medicaid, Bureau of Pharmacy Services, Bureau of Contract Management, and ACS	Ongoing
Provide new eligibles with Medicaid identification card and explanation of benefits	Division of Medicaid, Bureau of Contract Management and ACS	Ongoing and September 2002
Develop and implement marketing program	Agency for Health Care Administration and Department of Elder Affairs	July - August 2002 In Process
Monitor FLORIDA and FMMIS system to assess operation of system changes and edits	Division of Medicaid, Bureau of Contract Management, ACS and Department of Children and Families	Ongoing
Monitor pharmacy operations	Division of Medicaid, Bureau of Pharmacy Services, and Contractor	Ongoing

Financial Reporting

The budget neutrality agreement under this demonstration requires the state to capture and report financial expenditures in accordance with the special terms and conditions for 1) individuals enrolled in the demonstration (demonstration enrollee) and 2) the non-demonstration aged. This section of the operational protocol describes the policies and procedures that are necessary to implement the financial reporting requirements in Attachment A of the Special Terms and Conditions.

Florida will modify its Medicaid Management Information System (MMIS) in order to facilitate expanded expenditure and budget reporting to CMS for the following reporting objectives:

- reporting/claiming Federal Financial Participation (FFP);
- tracking against the 1-year expenditure targets and the 5-year FFP cap;
- estimating/budgeting;
- distinguishing expenditures separately for the individuals enrolled in the demonstration and for the non-demonstration aged populations; and
- distinguishing expenditures by date of service to report expenditures in the correct demonstration year.

The Medicaid and State Children's Health Insurance Program Budget and Expenditure System - (MBES/CBES)

All claims related to the budget neutrality agreement will be reported on the State's quarterly CMS-64 expenditure report via the MBES/CBES. After entering this system, the State will access the appropriate forms by selecting the CMS-64 button on the left side of the screen. The State will click-on add/modify, then select the appropriate waiver reporting form from the drop down menu provided at the bottom of the screen. This drop down menu will provide access to the reporting Forms CMS-64.9 WAIVER, CMS-64.9P WAIVER, CMS-64.10 WAIVER, and CMS-64.10P WAIVER. These forms add directly into the CMS-64 Summary Sheet. This insures that the State will receive Federal match for all Title XIX waiver expenditures. Once the appropriate form has been selected and entered, the State will either click-on the "add" bar to add a new waiver sheet or the "modify" bar to modify a waiver sheet that has already been entered into the system. Once this selection has been made, the next screen will provide a chart of all waivers for Florida. The chart provides information for each waiver by Waiver Type, Waiver Number, and Waiver Name. The waiver type column includes 1115, 1915(b),

and 1915(c) waivers. The next column provides the waiver number. For 1115 waiver numbers, a block is included that needs to be completed with the correct demonstration year (i.e., -01, -02, -03, etc.). The demonstration year entered into the system will be the demonstration year in which services were rendered or for which capitation payments were made. Lastly, the list is grouped by waiver name. The waiver name consists of those eligibility groups or reporting categories identified in the Special Terms and Conditions and/or Operational Protocol. The eligibility groups for this demonstration will be identified as 1) ***demonstration enrollee*** for individuals enrolled in the demonstration or 2) ***non-demonstration aged***. A separate CMS-64.9 WAIVER and/or CMS-64.9P WAIVER will be completed for each eligibility group covered under the budget neutrality agreement.

All capitation payments will be reported on line 18.A. of the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER. All fee-for-service (FFS) expenditures will be reported on the appropriate service line on the Forms CMS-64.9 WAIVER and CMS-64.9P WAIVER.

In order to achieve the necessary expenditure tracking by demonstration year, the last two digits of the "WAIVER NUMBER" data entry field will be extremely critical. The demonstration year is included as a part of the "WAIVER NUMBER" and is identified as a part of the extension. For example, Florida waiver number is 11W00153/ with the extension of 4-xx. The 4 represents the Atlanta Region and the xx represents the demonstration year.

> EX: Assume the implementation date was April 1, 1999. Expenditures reported for the quarter ended March 31, 20XX will be broken out by date of service and assigned to the correct demonstration year (/4-0X (current year) or /4-0X-1, etc.) on the current quarter expenditure report (03/31/XX). Capitation payments made in that same quarter (March 31, 20XX) for services covered in April 20XX will be claimed on the current quarter expenditure report (March 31, 20XX), but will be assigned to the next demonstration year (/2-0X+1).

Tracking of expenditures against the annual expenditure targets and the 5-year cap will begin (Use appropriate date). The "first demonstration year" for budget neutrality purposes will be defined as extending from (Use appropriate date) through (Use appropriate date. For expenditures being claimed for dates of service beginning June 1 of each succeeding demonstration year, replace the last two digits with -02 through -05, respectively. In this way, Florida and CMS will be able to track the 1115 demonstration expenditures to the correct year of the expenditure target/cap. The expenditures for each demonstration year will be automatically accumulated on the CMS-64 Waiver Expenditure Report - Schedule C. The State will access this report on a quarterly basis to monitor its expenditures under the budget neutrality cap.

All offsetting adjustments attributable to the budget neutrality agreement that would normally be reported on lines 9 or 10.C. of any CMS-64 will be reported on line l0.B. The MBES/CBES system does not allow for these adjustments to affect waiver

expenditures. Therefore, in order for these adjustments to be credited to the State's 1115 waiver expenditures, these offsets must be reported on line 10.B. and identified with the correct waiver information. This will allow these claims to be included in the CMS-64 Waiver Reports (Schedules A, B, and C) that the State will access and use as a tracking mechanism. Waiver Schedule A will provide waiver expenditures claimed for the current quarter. Waiver Schedule B will provide a cumulative total for previous waiver expenditures as reported, current quarter expenditures, and the total expenditures to date. Waiver Schedule C provides a breakout of waiver expenditures to date by WAIVER NAME, by demonstration year, and totals for both Total Computable (TC) and Federal Share (FS). For any other cost settlements (i.e., those not attributable to the budget neutrality agreement), the adjustments will be reported on lines 9 and 10.C., as instructed in the State Medicaid Manual.

General Reporting Requirements

For six months after implementation, AHCA will hold monthly calls to discuss demonstration progress. AHCA will submit quarterly progress reports on the following:

- summary of events that occurred during the quarter;
- problems/issues that were identified and the method at which they were solved;
- reports/charts of enrollment and expenditures
- summary of program accomplishments

Claims Processing

The Medicaid Prescription Drug Card System (PDCS) has been updated to process all claims submitted under the Silver Saver prescription program. PDCS is a stand-alone point of sale (POS) prescription drug claim processing system, which includes online, real-time Prospective Drug Utilization Review (ProDUR) for claims submitted directly from pharmacy providers. Once entered into the PDCS system, all claims pass through an identical adjudication process. The PDCS operates within the ACS/Consultec data center. PDCS will process all paper, batch and POS drug claims.

Cost Sharing

Under the Silver Saver Drug Program, eligibles will be required to contribute to the cost of a drug according to the following requirement:

Type of Drug	Beneficiary Cost Sharing
Generic	$2.00 per drug
Preferred Drug List Product	$5.00 per drug
Non-Preferred Drug List Brand Product	$15.00 per drug

Medicaid eligibles enrolled in this project will be informed of their cost sharing requirements through recipient mailings and by notice from Medicaid participating pharmacies. Co-payment amounts will appear in the benefit brochure, and will be an integral part of benefit advertising.

Pharmacies enrolled in Florida Medicaid will be responsible for collecting beneficiary co-payments prior to dispensing drugs. Pharmacies will have the right to deny service if a recipient fails to pay the mandatory co-payment.

At point of sale (POS), co-payments will be subtracted from the Medicaid allowable cost of each prescription. Pharmacy reimbursement for prescriptions will be as follows:

Medicaid Allowed Cost – Beneficiary Co-payment = Silver Saver Reimbursement

Co-payments will not increase over the life of this demonstration. However, beneficiaries will be responsible for any drug costs' that exceeds the $160 per month benefit limit.

Claims Example: *Generic Drug Purchase*

Beneficiary has $160 remaining in his/her monthly benefit balance and his/her Medicaid allowable generic prescription cost $30. The Beneficiary will pay the $2 co-payment and Silver Saver will pay the remaining $28.

Medicaid Allowable Generic Drug Cost = Silver Saver + Beneficiary Copayment
$30 $28 $2

The recipient will now have $132 remaining in his/her Silver Saver benefit balance.

Silver Saver Balance Before Purchase:	$160
Less: Amount Silver Saver Contributed to Purchase:	$28
Remaining Silver Saver Balance	$132

Claims Example: *PDL Drug Purchase*

Beneficiary has another $132 remaining in his/her monthly benefit balance and obtains another Medicaid allowable PDL prescription at a cost of $65. The beneficiary will pay the $5 co-payment and Silver Saver will pay the remaining $60.

Medicaid Allowable PDL Drug Cost = Silver Saver + Beneficiary Copayment
$65 60 $5

The recipient will now have $72 remaining in his/her Silver Saver benefit balance.

Silver Saver Balance Before Purchase: $132
Less: Amount Silver Saver Contributed to Purchase: $60
Remaining Silver Saver Balance $72

Claims Example: *Non-PDL drug purchase (Note that the Non-PDL Medicaid Allowable Cost exceeds the remaining Silver Saver Balance)* ***This example will show how a beneficiaries total out of pocket expenses could be more than the mandatory co-payment.***

Beneficiary now has $72 remaining in his/her monthly benefit balance and obtains another Medicaid allowable non-PDL prescription at a cost of $100. The beneficiary will pay the $15 co-payment plus the remainder that is above the individual's Silver Saver Balance.

Medicaid Allowable Non-PDL Drug Cost = Silver Saver + Beneficiary Copayment
$100 $72 $15 + $13

The recipient will now have $0 remaining in his/her Silver Saver benefit balance.

Silver Saver Balance Before Purchase: $72
Less: Amount Silver Saver Contributed to Purchase: $72
Remaining Silver Saver Balance $00

All co-payments collected will represent a net deduction in the cost of this program. Only the remaining balance paid by the State is eligible for Federal reimbursement. The amount of expenditures reported by the State quarterly on the CMS-64.9 Waiver forms will be net of all co-payments collected.

Benefit Balance

PDCS has been updated to maintain a benefit balance for each participant in the Silver Saver program. As beneficiaries fill prescriptions, the Silver Saver balance is reduces as follows:

Current Silver Saver Balance($160)
Less: (Medicaid Allowable Cost – Beneficiaries Co-payment)
Remaining Silver Saver Balance

At the beginning of each month a beneficiaries Silver Saver Balance is automatically reset to $160. The Silver Saver balance does not carry forward from month to month (i.e., the beneficiary must use the entire benefit during the month or lose it). If the beneficiary has exhausted the $160 benefit before the end of the month, the beneficiary will be responsible for the entire cost of any prescription purchased for remainder of the month. Any prescription purchased by beneficiaries after the monthly benefit has been exhausted will not be processed through the Medicaid POS claims processing system. Once beneficiaries have exhausted their monthly benefit they may be eligible to purchase Prescriptions under the Medicare Prescription Discount until the benefit is reset the following month. Florida Medicaid requires all participating pharmacies to give a discount of Average Wholesale Price minus 9% plus a $4.50 dispensing fee to any Florida resident with a Medicare card (S. 409.9066, F.S.). If a beneficiary is not eligible for the Medicare prescription discount, he or she must pay for the entire cost of his/her prescription from the pharmacy.

Florida Medicaid receives federal and supplemental rebates from pharmaceutical manufacturers for prescriptions purchased through Medicaid. The Silver Saver program will bill pharmaceutical manufacturers for federal and supplemental rebates on prescriptions purchased with the $160 benefit. Any prescriptions purchased after a beneficiary has exhausted his/her benefit limit will not be subject to federal and supplemental rebates.

Coordination with Private Health Insurance Coverage

The Agency will use normal third party recovery processes under this waiver for individuals eligible for drug benefits.

Specific third party insurance coverage is information is required on the application and is entered into the beneficiary's Medicaid file during application processing. When a Silver Saver beneficiary fills his or her prescription at the pharmacy, the POS system will automatically check for other third party prescription coverage on the beneficiary's eligibility file. If a beneficiary does not have third party coverage, the claim will pay. If PDCS recognizes that the beneficiary has third party coverage, the claim will not pay and will send a message, instructing the pharmacist to bill the third party coverage first. If the third party coverage will not pay the claim, the pharmacist must submit the claim on paper and attach the Explanation of Benefits (EOB) denial.

If a beneficiary fails to disclose third party insurance coverage on his or her application, AHCA can obtain the information through other avenues. Medicare coverage, including HMO enrollment, is also provided to the Agency via monthly tapes from CMS, which are processed by the Medicaid fiscal agent for updating recipient files. The Florida Medicaid third party recovery contractor, Health Management Systems (HMS), is responsible for the automated matching of eligibles with third party insurers to detect private insurance

coverages, including drug coverages, for updating files and to seek recovery of Medicaid payment if covered by a third party.

Pharmacy Services, Providers and Benefit Management

All pharmacy benefits covered under this waiver will be provided through the Florida Medicaid fee-for-service system. None of the beneficiaries eligible for this project are required to enroll in a managed care plan. The prescribed drug benefits will be provided through the approximately 3,300 Medicaid participating pharmacies. Any licensed pharmacy, not previously sanctioned and terminated from participation by the Agency, is eligible to enroll as a Medicaid pharmacy provider.

Pharmacies will be reimbursed for drugs provided under this project in the same way that they are paid for other Medicaid reimbursable prescriptions. Ingredient prices are set at the lower of Average Wholesale Price minus 13.25% or federal or state pricing limits. Pharmacies are paid a $4.23 dispensing fee for each drug dispensed.

Up to the monthly benefit limit, beneficiaries enrolled in this waiver program will have access to all FDA-approved branded and generic products except cosmetic, weight reduction and cough and cold products. Any branded drugs in excess of 4 drugs per month or non-PDL products will require prior authorization, as is the case with current Medicaid drug coverages.

Four Brand Limit/Therapeutic Consultation Program (TCP)

Florida requires that all Medicaid recipients age 21 and older be limited to four brand name drugs per month. Generic drugs, insulin and diabetic supplies, contraceptives, mental health drugs, and antiviral drugs used to treat HIV are exempt from the limitation. Prescribers may request exceptions to the four brand name limit and the Preferred Drug List (PDL), when it is medically appropriate and necessary, through the toll-free Therapeutic Consultation Program (TCP) call center operated by the Medicaid fiscal agent, ACS Consultec. Medicaid may approve exceptions for supplemental brand name products or non-PDL therapy for up to twelve months. All individuals participating in the demonstration will be held to the Medicaid four brand-name drug limit guidelines.

When a Silver Saver recipient hits the fifth brand, a denial message is triggered to the pharmacist at POS, indicating that the physician must call to provide medical justification for the prescription. During those times when the physician cannot be contacted (after hours, holidays), the pharmacist will have the option to issue a 72-hour supply using an override on the claim. This 72-hour supply will receive no dispensing fee. Only two such overrides will be available for a single prescription per month.

Once the prescribing physician is contacted, he or she then calls the TCP call center and begins discussion with one of the clinical pharmacists. The clinical pharmacist may need to obtain additional information concerning the beneficiary, such as co-morbid conditions, failed therapy trials, or external factors that will apply to this recipient. Once the clinical review of the beneficiary's history has been completed and other factors considered, the pharmacist will then discuss alternative options with the prescriber to modify the drug regimen to substitute a generic or PDL alternative if appropriate. When a prescriber agrees to change the fifth brand to a generic or PDL alternative, he or she calls in the changed prescription to the pharmacy. The TCP pharmacist enters this resolution into the system and closes out the call.

While the physician is still on the phone, the TCP pharmacist will also examine the beneficiary's entire drug profile to determine if there are any opportunities to replace previously dispensed brand medications with generic or PDL alternatives. If the physician agrees to change a previously dispensed medication, the TCP pharmacist will approve the fifth brand for one month only. The TCP pharmacist will then fax the physician a letter requesting confirmation that the prescription has been changed. Records of all such correspondence are maintained in a log for tracking and follow-up activity.

If the TCP pharmacist determines or if the prescriber insists that the drug profile being discussed simply presents no opportunities for substitution (i.e., no acceptable alternatives exist, given the recipients profile), he or she will approve the prescription plus refills.

In those cases where the TCP pharmacist identifies opportunities for prescribing generic or PDL alternatives but the physician refuses to change the medication, the TCP pharmacist will allow a 34-day supply of the prescription. The TCP pharmacist will then send a letter to that prescriber (and all other prescribers on the recipient's profile as well) that contains a copy of the beneficiary's drug profile and fax this approval back to the TCP call center. This correspondence is tracked by the TCP support staff and if no approval is received within two weeks, a follow-up letter is faxed to the prescriber. Once the prescriber approves the profile, the TCP pharmacist will authorize refills of that brand medication for the beneficiary. If no approval is received, any refills for the medication will receive the same cap limit reject in the system and the physician will have to reinitiate the process.

If the TCP pharmacist discovers opportunities to simplify the beneficiary's drug profile that are not the responsibility of the physician who initiates the call, the TCP pharmacist will contact the responsible prescriber and initiate the TCP Process.

All information concerning consultation activity (generic substitutions, physician refusals, etc.) is maintained by the Prescription Drug Card System (PDCS) for program activity reporting as well as potential follow-up. For example, ACS will monitor this data

to track doctors with high refusal rates and recipients whose prescriptions are consistently overridden for possible benefits management and educational intervention.

The TCP call center is available between 8am and 8pm Monday through Friday, excluding holidays, and 10am to 4pm on Saturday.

Intensified Benefits Management Program (IBM)

The Silver Saver demonstration will also use the current Medicaid Intensified Benefits Management Program (IBM) to provide another aspect of pharmaceutical benefit management to the recipients. The IBM involves the critical evaluation of treatment plans. The IBM program will provide an in-depth review and subsequent coordination of care aimed at involving all providers rendering care to a beneficiary. Utilizing an integrated, pharmacist-based case management model, IBM's goals include: providing long-term case management of beneficiaries; working to coordinate care among various providers; correcting of inappropriate prescribing behavior; and promoting cost-effective pharmaceutical care.

It is the policy of the IBM program to provide in-depth review of the pharmacy profiles of selected beneficiaries. The IBM pharmacist will review the drug profile of recipients referred to the program, develop strategies to improve the pharmaceutical care of those recipients, make recommendations to the treating physician(s), and document the outcomes of the intervention.

Individuals are generally referred to the IBM program through the TCP program. While the TCP pharmacist is reviewing recipient profiles and interacting with prescribing physicians on a daily basis, the TCP pharmacist may refer cases directly to the IBM as a result of recipient history observed during TCP activities. Opportunities for referral to IBM include drug regimens or prescribing behaviors that warrant further review such as:

- Recipients with therapeutic duplications
- Suspected recipient non-compliance
- Recipients utilizing multiple prescribers (continuity of care issues)
- Suspected drug misuse, overuse or abuse
- Long-term utilization of drugs intended for acute treatment (e.g., antibiotics, benzodiazepines, narcotics)
- Drug therapies that do not correspond with nationally recognized standards (e.g., chronic and routine use of B-agonist inhalers with no inhaled corticosteroid therapy)
- Daily doses that exceed those recommended by the manufacturer (e.g., Prozac > 80 mg/day, Prilosec > 40 mg/day)

Non-Preferred Drug List Prior Authorization

All non-PDL drugs purchased through Silver Saver require prior authorization. At POS, an online prior authorization notification is generated when the pharmacist tries to fill a prescription that is a non-PDL drug. The message prompts the pharmacy to inform the beneficiary's physician to call the TCP call center. During those times when the physician cannot be contacted (after hours, holidays), the pharmacist will have the option to issue a 72-hour supply using an override on the claim. This 72-hour supply will receive no dispensing fee. Only two such overrides will be available for a single prescription per month. Once the prescribing physician is contacted, he or she then calls the TCP call center and begins discussion with one of the clinical pharmacists. The TCP pharmacist reviews the recipient profile with the physician and offers preferred drug alternatives. If the physician rejects the preferred alternative or chooses the non-preferred drug and refuses to give a reason for non-compliance, the TCP pharmacist places a 30-day authorization for the drug on the recipient profile and generates a prior authorization letter that is sent to the physician. The TCP pharmacist informs the physician that the authorization letter has to be returned to ACS within the 30-day authorization time frame for the recipient to receive refills. If the physician provides a clinical rationale to the TCP pharmacist concerning the physicians' unwillingness to select a preferred drug alternative, a one-year override will be placed on the beneficiary's profile with no follow up letter required. If the physician chooses the preferred drug alternative, the drug is switched and called into the pharmacy.

Outreach/Marketing/Education

The State of Florida will implement a comprehensive, aggressive marketing program to alert seniors to new drug benefits available through Silver Saver. The marketing campaign will be coordinated by AHCA with the Department of Elder Affairs with assistance from the communications staff of the Executive Office of the Governor. The marketing campaign will have several elements, which may include but not be limited to the following:

- public service announcements;
- meetings with the editorial boards of Florida dailies;
- guest editorials and op-eds;
- poster campaigns;
- enlistment of the support of large, influential senior organizations, such as AARP;
- use of the existing aging services network, including Area Agencies on Aging, lead Community Care for the Elderly (CCE) agencies, and CCE providers (e.g., senior centers);
- letters to and campaigns with pharmacies;
- wide distribution of application materials;

- asking pharmacies/pharmacists to implement in-store promotions of the Silver Saver Program;
- asking provider organizations (e.g., Florida Medical Association, Florida Pharmacy Association) to communicate the new program to members and asking members to notify their patients of the new program;
- speaking at statewide and local conferences to promote the new program; and
- including program information and downloadable applications on state agency web sites.

PROJECT	DESCRIPTION	LEAD AGENCY	DEADLINE
Logo Design	Branded design for Silver Saver	AHCA	July 3, 2002 COMPLETED
Letter to Seniors	Letter to eligible seniors describing program	AHCA	July 5, 2002 COMPLETED
Press Conference	Miami/Tampa Governor, Sectretary Thompson, Agencies, Legislators, Seniors, AARP	AHCA and DOEA	July 29, 2002 IN PROGRESS
Posters, Brochure	11x17 4 color posters; tri-fold, 4 color brochure describing program	AHCA	July 29, 2002 COMPLETED
Op-ed Pieces	500 word article describing program	AHCA	Aug. 1, 2002 IN PROGRESS
Video/Audio Spots	30 second spots describing program; narration by well-known figure	AHCA/DOEA	Sept. 1, 2002 IN PROGRESS
External Outreach	Coordination of program with state associations	AHCA/DOEA	Sept. 1, 2002 IN PROGRESS

All informational materials will be translated into several languages, including Spanish and Creole.

Eligibility

Individuals eligible for the project include those age 65 and older with incomes between 88 percent and 120 percent of the federal poverty level and not enrolled in a Medicare HMO that provides a pharmacy benefit. Individuals applying for Silver Saver will not have to pass an asset test.

The Silver Saver program assumes all individuals with incomes below 88 percent of the federal poverty level qualify for a full Medicaid drug benefit. Individuals that fail to qualify for a full Medicaid drug benefit due to failing the required asset test will not be eligible for Silver Saver.

Enrollment

Existing Qualified Medicare Beneficiaries (QMB) and Specified Low Income Medicare Beneficiaries (SLMB) age 65 and older, who are currently on the Medicaid files with incomes between 88 and 120 percent of the federal poverty level, will be automatically enrolled and have their new drug benefit activated August 1, 2002.

Individuals qualifying for the drug-only benefit (QMB/SLMB-like but do not go through an asset test and are not on the current Medicaid files) will be activated starting September 1, 2002. Applications for this group, however, will be accepted beginning August 1, 2002. Those qualifying under QMB/SLMB will automatically receive the drug benefit available under this program. Those qualifying without an asset test will have their eligibility determined initially and annually redetermined by the Department of Children and Families.

Applications will be available at local DCF offices, various Medicaid participating pharmacies, Medicaid area offices, online, or can be requested from the Agency for Health Care Administration call center. The application can be dropped off at a DCF office or mailed to a central location. No face-to-face interview will be required.

All Silver Saver applications will be processed at the centralized location within 45 days of application date (applications dropped off at local DCF offices will be internally forwarded to the centralized processing location). Individuals inquiring about the Silver Saver prescription program can do so by calling the AHCA call center at 1-888-419-3456.

Enrollment will be capped at 58,472. Once this enrollment level is reached, the Medicaid fiscal agent will maintain an automated waiting list in date order. When there

is a disenrollment or termination, the Medicaid fiscal agent will transfer someone from the waiting list to the active enrollment list in date order. This replacement will occur each day. Once an individual on the waiting list is moved to active enrollment, the individual will receive a letter informing him that he is now eligible for payment of drug benefits and will receive the Florida Medicaid ID card for use at the pharmacy.

The Department of Children and Families will also notify applicants of other possible coverages (e.g., Medically Needy) and the Agency will keep beneficiaries apprised of any new developments at the federal or state level that could affect their drug coverages (e.g., adoption of a Medicare drug benefit).

Quality

The Agency will have overall monitoring responsibility for the Silver Saver program. Monitoring will include:

- assessment of application levels compared to enrollment limits and marketing initiatives;
- analysis of application processing times; DCF will monitor the fluctuation of application receipt to eligibility determination on a monthly basis
- assessments of the accuracy of eligibility determinations; DCF will use the current eligibility assessments on a quarterly basis
- assessment of FMMIS edits regarding benefit limits; Medicaid Bureau of Contract Management will use current Medicaid FMMIS assessments
- monitoring of pharmacy receipt of co-payments; AHCA will monitor recipient co-payment collections on a quarterly basis
- assessment of level of compliance with PDL; AHCA will asses PDL compliance on a quarterly basis
- assessment of the use of drug benefit by drug type and amount; AHCA will asses on a quarterly basis
- beneficiary and pharmacy profiling on drug utilization; ACS will assess on a quarterly basis using current Medicaid standards
- pharmacy audits; and
- other types of monitoring.

Grievances and Appeals

The beneficiary grievance and appeal process will be the same as that used for non-demonstration Medicaid beneficiaries.

Evaluation Design

The State of Florida will evaluate the Silver Saver Drug program to test a number of hypotheses.

- prescription drug coverage for the elderly leads to better health outcomes;
- prescription drug coverage for the elderly leads to the reduction of unnecessary medical interventions while remaining cost neutral to Medicaid;
- successful maximization of generic and preferred drug list products without affecting quality of care;
- the effect of cost sharing levels on drug use vs. drug need.

The following indicators will be monitored with frequencies as noted:

- enrollment statistics (Monthly);
- waiting list (Daily);
- expenditures: (Quarterly);
    - program expenditures;
    - PMPM averages (i.e., average prescription cost, number of prescriptions, amount of benefit used);
    - generic/PDL/non-PDL;

- claims counts (Quarterly);
- generic, PDL and non PDL usage (Quarterly).

Data will be collected using current Medicaid claims analysis software.

Interaction with Other Federal and/or State Programs

Waiver recipients will be in discrete eligibility categories. Generally, Medicaid waiver coverages would be accessed before other state-funded drug coverages. Individuals eligible for Silver Saver will be assessed for other Medicaid eligibility coverages at the time of application or when they lose coverage. Under current Medicaid guidelines, Silver Saver beneficiaries are not entitled to Florida Medicaid disease management programs because of the income limits in Silver Saver are higher than those required by the Medicaid disease management programs. However, individuals that do not qualify for Silver Saver will be referred to other programs that may supplement their drug coverages, such as manufacturer pharmaceutical assistance programs, manufacturer discount programs, pharmacy programs operated by state and local programs, such as those operated by the county health departments, federally qualified health centers, the AIDS Drug Assistance Program, or those run by local entities.